Integrated Manual Physical Therapy

20325 N 51st Ave Suite 134
Glendale, AZ 85308
Phone: 313-461-3805
E-Mail:imptaz1@gmail.com
Web: www.imptaz.com

PATIENT INFORMATION:

Name:_____ Date of Birth:_____
Name of Parent/Guardian if Minor: _____
Address:_____
Cell Phone:( )_____Home Phone:( )_____
Email:_____ Hobbies/Occupation_____
Emergency Contact: _____ Phone:( ) _____
Referring Doctor: _____Phone:( ) _____

FINANCIAL POLICY:

Integrated Manual Physical Therapy, PLLC (IMPT) provides physical therapy on a "fee at time of service" basis. By removing IMPT from the insurance companies, it does not have to limit the time or quality of treatment provided because of insurance company restrictions or elevate our rates to pay for billing services. I understand that I, the patient, am entering into care as a "cash-pay" client. By signing this agreement, I understand that IMPT will not be billing my insurance. I understand that my reimbursement benefits for Physical Therapy received at IMPT are out-of-network services and reimbursement is not guaranteed.

I agree to pay IMPT for my treatments at time of service, by cash, Zelle, or check. I understand there is a $35 returned check fee. If I need to cancel my appointment I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, **I will be charged and pay the full visit fee.** _____**(initial)**

CONDITIONS FOR TREATMENT:

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist can share with me opinions and available studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

I understand that in order for physical therapy treatment to be most effective, I must come to scheduled appointments and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. I understand that IMPT asks me not to wear perfumes and strong scents to treatments.

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION:

I authorize the mutual exchange of information regarding myself between IMPT and the following persons or professionals:

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OR UNDERSTANDING OF PRIVAVCY NOTICE: I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have read the online HIPPA document and have the right to receive a complete detailed copy of the ***NOTICE OF PRIVACY PRACTICES*** *upon request*.

_____**(initial)**

CONSENT FOR TREATMENT OF VISCERAL AND MANUAL THERAPY:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The following information is to inform you of potential risks and benefits. I hereby voluntarily consent to physical therapy treatment.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. You may experience tenderness, bruising, warmth, redness, aching, increased or decreased gastrointestinal motility, or other mild symptoms in general vicinity of tissues treated. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my physical therapist or physician.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. Improved energy, mobility, and gastrointestinal function. You will have greater knowledge about managing your condition and resources.

I, the patient, understand in order to best treat my condition that external manual therapy techniques may be performed in the anterior chest region *near* breast tissue, the anterior pelvic region *near* genital tissue and structures, and in the posterior and inferior gluteal region near rectum and pelvic bones including sacrum, coccyx, and ischial tuberosities. At any time if I am uncomfortable with any treatment I will immediately tell my therapist and I understand that I can decline any portion of the evaluation or treatment at any time.

I grant permission to all therapists I may see at IMPT to using all of the techniques they know, including Soft tissue mobilization, Visceral mobilization, Joint mobilization, Myofascial Release techniques, TMJ techniques, Proprioceptive Neuromuscular Facilitation (PNF) techniques, therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me until I am discharged from care. _____**(initial)**

*********I have read and fully understand the statements made on this form and agree that they apply to all treatments I receive from Integrated Manual Physical Therapy, PLLC. I know I am responsible for all services received and I agree to pay for any and all services rendered at the time of service unless previous arrangements have been made. By signing this document I agree to the conditions stated in this form*******

Patient/Guardian signature _____ Date_____

WHAT ARE YOUR PRIMARY CONCERNS?_____

_____

WHAT DO YOU FEEL MAY HAVE CONTRIUBUTED TO YOUR ISSUE?_____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

_____Changes in my bladder or bowels function
_____ Swelling in ankles/feet or hands
_____ Numbness or tingling in feet/legs or hands/arms
_____ Unexplainably lost or gained more than 10 pounds
_____ I have had recent internal bleeding (ulcer, intestinal, etc.)
_____ I have an implant (IUD, pacemaker, stent, other)
_____ Eating changes my symptoms
_____ Blurred vision
_____ I feel dizzy
_____ I wake with night pain
_____ I have had a recent infection
_____ I am pregnant or plan to start

List Medications you are taking: -

_____
_____
_____

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Pediatric Physical Therapy
Individualized Needs Assessment/Intake Form

Child's Full Name: _____Child's Date of Birth: _____

Name of person completing this form: _____ # of Siblings/ages_____

Relationship to child: _____

Home phone: _____ Cell Phone: _____ email: _____

Referral Information:

Who referred for therapy? :_____

What is your main concern regarding your child? : _____

When these concerns were first noticed? : _____

What do you see as your child's strengths? :_____

What are your goals for therapy? :_____

Pediatrician/Primary Care Physician: Name: _____

: Phone Number: _____

Birth History/Neonatal Period:

Child was born: Full term: no_____ yes_____ Number of weeks premature: _____

Child's delivery was: Vaginal _____ Cesarean _____ Forceps _____ Suction_____ length of labor_____

Describe any problems during pregnancy, labor, or delivery: _____

Did mother have prenatal care? _____

Birth Weight: _____Birth Length_____

Was your child in the NICU? _____NO_____YES If YES how long? _____

Medical Problems at
birth:_____

_____

List any specialist your child has seen and why (other than pediatrician or family
doctor)_____

_____

Sleep/Nap Schedule (number of naps/day and length of nap): _____

Night-time sleeping: (length and reason for not sleeping through night)—for infants, at what age did infant sleep through the night?

_____

_____

Medical History:

Other health care professionals involved in care:

_____

Family History:

Has your child had any of the following? ***Family history, please circle.***

___ADD/ADHD ___Congenital Heart Disease ___AIDS/HIV ___Chronic Colds

___Asthma ___Autism ___Bronchitis ___Head Injury

___Colic ___Ear Infection ___Headaches ___Skin Rash

___High Fever ___Seizures ___Other_____

Are immunizations up to date currently? _____yes_____no. Please provide reason: _____

_____

Surgeries; type and date: _____

Does your child wear glasses? _____

Medications your child currently taking:

_____

List any allergies to food or medications: _____

Are there any medical precautions of which she should be aware of when with your child?_____

_____

Physical Development:

Please indicate at what age your child achieved the following developmental milestones:

Rolled Over_____ Toilet Trained: _____

Sat up independently: _____ Self Fed Finger Foods: _____

Crawled on hands and knees: _____ Spoon-fed self: _____

Pulled to stand: _____ Slept through the night: _____

Walked: _____ Talked with simple words: _____

Used a cup: _____ Use crayon to color: _____

Ate solid foods: _____ Put two words together: _____

Jumping: _____ Running: _____

If school age, what school is the child enrolled in: _____

IEP: _____YES _____NO

Additional comments:

_____

_____

_____

_____
_____

Additional Information:

Please list a few of your child's favorite toys and games:

_____
_____

List any information that might be helpful in understanding your child:

_____
_____

Signature of person completing this form: _____ Date:_____